DOH\BES
Form 20M 1\98

# MENTAL STATUS & TREATMENT/PROGRESS REPORT

## TO THE MENTAL HEALTH CARE PROVIDER:

This person **[ ]** is applying for Medicaid Disability Benefits, or
**[ ]** is currently receiving Benefits and his/her case is up for review.

In order for us to evaluate this person's qualifications to receive benefits, we need medical evidence as to the nature of his/her condition, and the severity of the associated impairment.

**This form should be completed by the TREATING PHYSICIAN or therapist.**
Please complete the form based on your knowledge of this individual, using existing treatment and progress records and results of previous evaluations, as well as current observations.

A narrative report, covering the following points, may be substituted instead of this form.
**NOTE:** A history (from existing records) of treatment and progress, as well as a description of demonstrable signs and observations, is far more useful than a subjective report from the client.

**DO NOT** give the report to the client. **Return the completed report to the worker.**

| | | |
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| **Worker's Name**<br>**Title**<br>**Department** | **Worker's Address** | **Worker's Phone #** |
| **Client's Name** | **Social Security Number** | **Client ID#** |

## TO THE WORKER:

**This form should be sent to the person who treats the client for his mental problems.**

Please **include a pre-addressed return envelope** that the provider can use to return the completed form/report in. Completed form/report should not be given to the client. Include your name, address and telephone number above, so the provider can contact you if necessary.

Include a completed form **MI 706 Request for Medical Information** with the form 20M. The doctor will use the MI 706 for payment purposes. If the doctor requests additional evaluations or testing before completing the form 20M, refer him/her to the instructions and phone number on the back of the MI 706.

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| **1.** | Patient's Name | Social Security Number | Client ID# |
| **2.** | Name of Reporting Physician (Printed/Typed) | Title | Phone |
| **3.** | Patient First Examined | Date of Last Examination | Frequency of Visits |
| **4.** | **GENERAL OBSERVATIONS:** Does the patient require assistance to keep his/her appointments? In what way and by whom? Please describe posture, gait, mannerisms, and general appearance. | | |
| **5.** | **PRESENT ILLNESS:** What are the patient's complaints and symptoms? How and when did they begin? Is this a new condition, or an exacerbation of a chronic condition? | | |
| **6.** | **PAST HISTORY OF TREATMENT:** If patient has been hospitalized, please indicate dates, location, and course of treatment. Also describe any outpatient treatment, including Day treatment, Residential Treatment facilities, etc.. | | |

**7.** **FAMILY, SOCIAL, AND ENVIRONMENTAL HISTORY:** Briefly discuss the following areas, if relevant; family, education, marriage, divorce, work, sickness, alcohol, drug abuse, prison, etc.

**8A.** **ATTITUDE AND BEHAVIOR:** Please describe the patient's general attitude, e.g., pleasant, hostile, relaxed, fearful, etc., and any examples of noteworthy behaviors, e.g., tearfulness, motor activity, explosive behavior, etc.

**B.** **INTELLECTUAL FUNCTIONING/SENSORIUM:** Please describe and provide specific examples of orientation, memory, concentration, signs of organicity, judgement, etc. Include copies of any test results available to you.

**C.** **AFFECTIVE STATUS:** Please present any evidence of anxiety, depression, phobias, psychophysiological disturbances, conversion symptomatology, suicidal/homicidal ideation, etc. Describe any physical manifestations, e.g. tremors, weight change, insomnia, etc.

**D.** **REALITY CONTACT:** Does the patient present delusions, hallucinations, paranoid ideation, confusion, mood swings, emotional lability, emotional withdrawal/seclusiveness, bizarre/unusual behavior, etc? Please describe in detail.

**9A.** **PRESENT DAILY ACTIVITIES:** Discuss the degree of assistance or direction needed to properly care for personal affairs, do shopping, work, drive a car, etc. In what ways, if any, have the patient's daily activities changed as a result of the patient's mental condition?

**B.** **PRESENT INTERESTS:** Describe the patient's interests and use of free time such as family, home, friends, business, politics, sports, hobbies, projects, etc. In what ways, if any, have these changed as a result of the patient's mental condition?

**C.** **ABILITY TO RELATE:** Describe how patient gets along with and communicates with family members, neighbors, friends, fellow employees, supervisors, etc. In what way has this changed as a result of the patient's condition?

**D.** **PERSONAL HABITS:** Describe the patient's grooming, clothing, hygiene, etc. In what ways, if any, have personal habits changed as a result of the patient's mental condition?

**10.** **MEDICATION:** DOSAGE AND FREQUENCY.

**11.** **DIAGNOSIS:**

**12.** **PROGNOSIS:** Can the patient's condition be expected to improve? If so, when do you consider significant change likely to occur?

**13.** **COMPETENCY:** Is patient competent to manage funds on his/her behalf?

**14.** **ADDITIONAL COMMENTS:** Attach additional pages, if necessary.

**15.**

| Signature of Physician | Date |
|---|---|

**NOTE: If completed and signed by other than an MD/PhD**, an LCSW for instance, the form needs to be cosigned by an MD or PhD. If copies of previous reports (signed by an MD or PhD ) are included, this form would not need to be cosigned.

**DO NOT** give the report to the client. **Please return the completed report to the worker**.